1. Inpatient Hospital Services (Continued)

Non-State Public Hospital Inpatient Adjustment

Effective April 19, 2001, all Arkansas non-state government-owned or operated acute care and critical access hospitals (that is, all acute care and critical access government hospitals within the state of Arkansas that are neither owned nor operated by the state of Arkansas) shall qualify for a public hospital inpatient rate adjustment. **Effective November 1, 2004, Arkansas may provide a public inpatient rate adjustment to non-state government owned or operated acute care regional medical center hospitals located outside of Arkansas (that is, acute care hospitals outside of Arkansas that are neither owned nor operated by any state) that - a) provide level 1 trauma and burn care services; b) provide level 3 neonatal care services; c) are obligated to serve all patients, regardless of State of origin; d) are located within a Standard Metropolitan Statistical Area (SMSA) that includes at least 3 States, including Arkansas; e) serve as a tertiary care provider for patients residing within a 125 mile radius; and f) meet the criteria for disproportionate share hospital under Section 1923 of the Social Security Act in at least one State other than the one in which the hospital is located.** The adjustment shall result in total payments to each hospital that are equal to but not in excess of the individual facility=s Medicare-related upper payment limit, as prescribed in 42 C.F.R. ə 447.272. The adjustment shall be calculated as follows:

1. Using data from the hospital=s most recently audited cost report, Arkansas shall determine each **eligible** non-state public hospital=s base Medicare per discharge rate and base Medicaid per discharge rate. Base Medicare and Medicaid per discharge rates will include respective Case Mix Index (CMI) adjustments in order to neutralize the impact of the differential between Medicare and Medicaid case mixes.

   For hospitals who, for the most recently audited cost report year filed a partial year cost report, such partial year cost report data shall be annualized to determine their rate adjustment; provided that such hospital was licensed and providing services throughout the entire cost report year. Hospitals with partial year cost reports who were not licensed and providing services throughout the entire cost report year shall receive pro-rated adjustments based on the partial year data.

2. The base Medicare per discharge rate shall be multiplied by the applicable upper payment limit (percentage) specified in 42 C.F.R. ə 447.272 for non-state government owned or operated hospitals. For example, to the extent that such federal regulation permits Medicaid payments up to 150 percent of the amount that would be paid under Medicare reimbursement principles, the base Medicare per discharge rate shall be multiplied by 150 percent. The result shall be the adjusted Medicare per discharge rate.

3. The base Medicaid per discharge rate shall be subtracted from the adjusted Medicare per discharge rate determined pursuant to step 2.

1. Inpatient Hospital Services (Continued)

Non-State Public Hospital Inpatient Adjustment (continued)

4. The difference shall be multiplied by the number of Medicaid discharges at the hospital for the most recent audited fiscal year. The result shall be the amount of the annual Non-State Public Hospital Adjustment.

5. Payment shall be made on a quarterly basis within 15 days after the end of the quarter for the previous quarter. Payment for SFY 2001 shall be prorated proportional to the number of days between April 19, 2001 and June 30, 2001 to the total number of days in SFY 2001.